SENATE BILL No. 294

DIGEST OF INTRODUCED BILL

Citations Affected: IC 22-3.

Synopsis: Worker's compensation. Changes the worker's compensation and occupational diseases compensation law by providing that: (1) a medical service provider may not be reimbursed for more than one office visit for each repackaged legend drug prescribed; (2) the maximum period during which a medical service provider that is not a retail or mail order pharmacy may receive reimbursement for a repackaged legend drug begins on the date of the injury or disablement and ends at the beginning of the eighth day after the date of the injury or disablement; (3) the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation or occupational diseases compensation and provided by a medical service facility is established by payment of: (A) a negotiated amount; (B) an amount not to exceed 150% of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate; or (C) an amount not less than 125% of the cost to the medical service facility of the specific service or product provided; (4) reimbursement for an implant may not exceed the amount of the medical service facility's actual acquisition cost as evidenced by an invoice from the implant manufacturer, plus 25% and must be reduced by the amount of any financial incentive that the medical service facility receives or benefits from in connection with the implant; (5) a medical service provider may not receive more than one reimbursement for an implant; (6) the term "medical service provider" does not include a medical case manager or another person who assists in the planning, coordination, monitoring, or evaluation of

(Continued next page)

Effective: July 1, 2014.

Boots

January 14, 2014, read first time and referred to Committee on Pensions and Labor.

medical services provided to an employee; and (7) for purposes of determining pecuniary liability, distinguishes a medical service provider from a medical service facility on the basis of the provider's billing form for Medicare reimbursement.

Introduced

Second Regular Session 118th General Assembly (2014)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2013 Regular Session and 2013 First Regular Technical Session of the General Assembly.

SENATE BILL No. 294

A BILL FOR AN ACT to amend the Indiana Code concerning labor and safety.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 22-3-3-4.5, AS ADDED BY P.L.275-2013, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 4.5. (a) As used in this section, "legend drug" has the meaning set forth in IC 25-26-14-7.

(b) As used in this section, "repackage" has the meaning set forth in IC 25-26-14-9.3.

(c) This subsection does not apply to a retail or mail order pharmacy. Except as provided in subsection (d), whenever a prescription covered by IC 22-3-2 through IC 22-3-6 is filled using a repackaged legend drug:

(1) the maximum reimbursement amount for the repackaged legend drug must be computed using the average wholesale price set by the original manufacturer for the legend drug;

(2) the medical service provider may not be reimbursed for

more than one (1) office visit for each repackaged legend drug prescribed; and

(3) the maximum period during which a medical service provider may receive reimbursement for a repackaged legend drug begins on the date of the injury and ends at the beginning of the eighth day after the date of the injury.

(d) If the National Drug Code (established under Section 510 of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. 360) for a legend drug cannot be determined from the medical service provider's billing or statement, the maximum reimbursement amount for the repackaged legend drug under subsection (c) is the lowest cost generic for that legend drug.

SECTION 2. IC 22-3-3-5.2, AS AMENDED BY P.L.275-2013, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 5.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation provided before July 1, 2014, by all medical service providers, and after June 30, 2014, by a medical service provider that is not a medical service facility:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(b) This subsection applies after June 30, 2014, to a medical service facility. The pecuniary liability of an employer or an employer's

insurance carrier for a specific service or product covered under worker's compensation and provided by a medical service facility is equal to a reasonable amount, which is established by payment of one (1) of the following:

(1) The amount negotiated at any time between the medical service facility and any of the following:

(A) The employer.

(B) The employer's insurance carrier.

(C) A billing review service on behalf of a person described in clause (A) or (B).

(D) A direct provider network that has contracted with a person described in clause (A) or (B).

(2) **An amount not to exceed** ~~Two~~ **one** hundred **fifty** percent ~~(200%)~~ **(150%)** of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1).

(3) An amount not less than one hundred twenty-five percent (125%) of the cost to the medical service facility of the specific service or product provided, if an amount has not been negotiated as described in subdivision (1). For purposes of this subdivision, "cost" means the expenses incurred by the medical service facility in rendering patient care, but does not include operating expenses not related to patient care. If the medical service facility disputes a payment made under this subdivision, neither the amount described in subdivision (2) nor the amount billed under this subdivision is presumed to be correct. The worker's compensation board shall accept any evidence that rationally establishes the basis for calculating the medical service facility's cost in determining the amount paid under this subdivision.

(c) The payment to a medical service provider for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the **amount of the medical service facility's actual acquisition cost as evidenced by an** invoice ~~amount~~ **from the implant manufacturer to the medical service facility** plus twenty-five percent (25%). **The actual acquisition cost must be reduced by the amount of any financial incentive that the medical service facility receives or benefits from in connection with the implant, including a rebate, discount, recall, or reduction. A medical service provider may not receive more than one (1) reimbursement for an implant furnished**

to an employee under IC 22-3-2 through IC 22-3-6.

(d) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) or Medicare coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the service or product at the eightieth percentile; and

(4) in the case of a CPT or Medicare coding change, the basis upon which the change was made;

not later than thirty (30) days after the date of the request.

(e) If, after a hearing, the worker's compensation board finds that a billing review service used a billing review standard that did not comply with subsection (a)(1) through (a)(3), as applicable, in determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under worker's compensation, the worker's compensation board may assess a civil penalty against the billing review service in an amount not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000).

SECTION 3. IC 22-3-6-1, AS AMENDED BY P.L.275-2013, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the context otherwise requires:

(a) "Employer" includes the state and any political subdivision, any municipal corporation within the state, any individual or the legal representative of a deceased individual, firm, association, limited liability company, or corporation or the receiver or trustee of the same, using the services of another for pay. A parent corporation and its subsidiaries shall each be considered joint employers of the corporation's, the parent's, or the subsidiaries' employees for purposes of IC 22-3-2-6 and IC 22-3-3-31. Both a lessor and a lessee of employees shall each be considered joint employers of the employees provided by the lessor to the lessee for purposes of IC 22-3-2-6 and IC 22-3-3-31. If the employer is insured, the term includes the employer's insurer so far as applicable. However, the inclusion of an employer's insurer within this definition does not allow an employer's

insurer to avoid payment for services rendered to an employee with the approval of the employer. The term also includes an employer that provides on-the-job training under the federal School to Work Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth in IC 22-3-2-2.5. The term does not include a nonprofit corporation that is recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to the extent the corporation enters into an independent contractor agreement with a person for the performance of youth coaching services on a part-time basis.

(b) "Employee" means every person, including a minor, in the service of another, under any contract of hire or apprenticeship, written or implied, except one whose employment is both casual and not in the usual course of the trade, business, occupation, or profession of the employer.

(1) An executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation, other than a municipal corporation or governmental subdivision or a charitable, religious, educational, or other nonprofit corporation, is an employee of the corporation under IC 22-3-2 through IC 22-3-6. An officer of a corporation who is the sole officer of the corporation is an employee of the corporation under IC 22-3-2 through IC 22-3-6, but may elect not to be an employee of the corporation under IC 22-3-2 through IC 22-3-6. If an officer makes this election, the officer must serve written notice of the election on the corporation's insurance carrier and the board. An officer of a corporation who is the sole officer of the corporation may not be considered to be excluded as an employee under IC 22-3-2 through IC 22-3-6 until the notice is received by the insurance carrier and the board.

(2) An executive officer of a municipal corporation or other governmental subdivision or of a charitable, religious, educational, or other nonprofit corporation may, notwithstanding any other provision of IC 22-3-2 through IC 22-3-6, be brought within the coverage of its insurance contract by the corporation by specifically including the executive officer in the contract of insurance. The election to bring the executive officer within the coverage shall continue for the period the contract of insurance is in effect, and during this period, the executive officers thus brought within the coverage of the insurance contract are employees of the corporation under IC 22-3-2 through IC 22-3-6.

(3) Any reference to an employee who has been injured, when the

employee is dead, also includes the employee's legal representatives, dependents, and other persons to whom compensation may be payable.

(4) An owner of a sole proprietorship may elect to include the owner as an employee under IC 22-3-2 through IC 22-3-6 if the owner is actually engaged in the proprietorship business. If the owner makes this election, the owner must serve upon the owner's insurance carrier and upon the board written notice of the election. No owner of a sole proprietorship may be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received. If the owner of a sole proprietorship:

(A) is an independent contractor in the construction trades and does not make the election provided under this subdivision, the owner must obtain a certificate of exemption under IC 22-3-2-14.5; or

(B) is an independent contractor and does not make the election provided under this subdivision, the owner may obtain a certificate of exemption under IC 22-3-2-14.5.

(5) A partner in a partnership may elect to include the partner as an employee under IC 22-3-2 through IC 22-3-6 if the partner is actually engaged in the partnership business. If a partner makes this election, the partner must serve upon the partner's insurance carrier and upon the board written notice of the election. No partner may be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received. If a partner in a partnership:

(A) is an independent contractor in the construction trades and does not make the election provided under this subdivision, the partner must obtain a certificate of exemption under IC 22-3-2-14.5; or

(B) is an independent contractor and does not make the election provided under this subdivision, the partner may obtain a certificate of exemption under IC 22-3-2-14.5.

(6) Real estate professionals are not employees under IC 22-3-2 through IC 22-3-6 if:

(A) they are licensed real estate agents;

(B) substantially all their remuneration is directly related to sales volume and not the number of hours worked; and

(C) they have written agreements with real estate brokers stating that they are not to be treated as employees for tax purposes.

(7) A person is an independent contractor and not an employee

under IC 22-3-2 through IC 22-3-6 if the person is an independent contractor under the guidelines of the United States Internal Revenue Service.

(8) An owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier is not an employee of the motor carrier for purposes of IC 22-3-2 through IC 22-3-6. The owner-operator may elect to be covered and have the owner-operator's drivers covered under a worker's compensation insurance policy or authorized self-insurance that insures the motor carrier if the owner-operator pays the premiums as requested by the motor carrier. An election by an owner-operator under this subdivision does not terminate the independent contractor status of the owner-operator for any purpose other than the purpose of this subdivision.

(9) A member or manager in a limited liability company may elect to include the member or manager as an employee under IC 22-3-2 through IC 22-3-6 if the member or manager is actually engaged in the limited liability company business. If a member or manager makes this election, the member or manager must serve upon the member's or manager's insurance carrier and upon the board written notice of the election. A member or manager may not be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received.

(10) An unpaid participant under the federal School to Work Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the extent set forth in IC 22-3-2-2.5.

(11) A person who enters into an independent contractor agreement with a nonprofit corporation that is recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to perform youth coaching services on a part-time basis is not an employee for purposes of IC 22-3-2 through IC 22-3-6.

(12) An individual who is not an employee of the state or a political subdivision is considered to be a temporary employee of the state for purposes of IC 22-3-2 through IC 22-3-6 while serving as a member of a mobile support unit on duty for training, an exercise, or a response, as set forth in IC 10-14-3-19(c)(2)(B).

(c) "Minor" means an individual who has not reached seventeen (17) years of age.

(1) Unless otherwise provided in this subsection, a minor employee shall be considered as being of full age for all purposes

of IC 22-3-2 through IC 22-3-6.

(2) If the employee is a minor who, at the time of the accident, is employed, required, suffered, or permitted to work in violation of IC 20-33-3-35, the amount of compensation and death benefits, as provided in IC 22-3-2 through IC 22-3-6, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of the compensation or benefits that may be payable on account of the injury or death of the minor, and the employer shall be liable for the other one-half (1/2) of the compensation or benefits. If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age and who at the time of the accident is employed, suffered, or permitted to work at any occupation which is not prohibited by law, this subdivision does not apply.

(3) A minor employee who, at the time of the accident, is a student performing services for an employer as part of an approved program under IC 20-37-2-7 shall be considered a full-time employee for the purpose of computing compensation for permanent impairment under IC 22-3-3-10. The average weekly wages for such a student shall be calculated as provided in subsection (d)(4).

(4) The rights and remedies granted in this subsection to a minor under IC 22-3-2 through IC 22-3-6 on account of personal injury or death by accident shall exclude all rights and remedies of the minor, the minor's parents, or the minor's personal representatives, dependents, or next of kin at common law, statutory or otherwise, on account of the injury or death. This subsection does not apply to minors who have reached seventeen (17) years of age.

(d) "Average weekly wages" means the earnings of the injured employee in the employment in which the employee was working at the time of the injury during the period of fifty-two (52) weeks immediately preceding the date of injury, divided by fifty-two (52), except as follows:

(1) If the injured employee lost seven (7) or more calendar days during this period, although not in the same week, then the earnings for the remainder of the fifty-two (52) weeks shall be divided by the number of weeks and parts thereof remaining after the time lost has been deducted.

(2) Where the employment prior to the injury extended over a period of less than fifty-two (52) weeks, the method of dividing

the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed, if results just and fair to both parties will be obtained. Where by reason of the shortness of the time during which the employee has been in the employment of the employee's employer or of the casual nature or terms of the employment it is impracticable to compute the average weekly wages, as defined in this subsection, regard shall be had to the average weekly amount which during the fifty-two (52) weeks previous to the injury was being earned by a person in the same grade employed at the same work by the same employer or, if there is no person so employed, by a person in the same grade employed in the same class of employment in the same district.

(3) Wherever allowances of any character made to an employee in lieu of wages are a specified part of the wage contract, they shall be deemed a part of the employee's earnings.

(4) In computing the average weekly wages to be used in calculating an award for permanent impairment under IC 22-3-3-10 for a student employee in an approved training program under IC 20-37-2-7, the following formula shall be used. Calculate the product of:

(A) the student employee's hourly wage rate; multiplied by

(B) forty (40) hours.

The result obtained is the amount of the average weekly wages for the student employee.

(e) "Injury" and "personal injury" mean only injury by accident arising out of and in the course of the employment and do not include a disease in any form except as it results from the injury.

(f) "Billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(g) "Billing review standard" means the data used by a billing review service to determine pecuniary liability.

(h) "Community" means a geographic service area based on ZIP code districts defined by the United States Postal Service according to the following groupings:

(1) The geographic service area served by ZIP codes with the first three (3) digits 463 and 464.

(2) The geographic service area served by ZIP codes with the first three (3) digits 465 and 466.

(3) The geographic service area served by ZIP codes with the first three (3) digits 467 and 468.

(4) The geographic service area served by ZIP codes with the first three (3) digits 469 and 479.

(5) The geographic service area served by ZIP codes with the first three (3) digits 460, 461 (except 46107), and 473.

(6) The geographic service area served by the 46107 ZIP code and ZIP codes with the first three (3) digits 462.

(7) The geographic service area served by ZIP codes with the first three (3) digits 470, 471, 472, 474, and 478.

(8) The geographic service area served by ZIP codes with the first three (3) digits 475, 476, and 477.

(i) "Medical service provider" refers to a person or an entity that provides services or products to an employee under IC 22-3-2 through IC 22-3-6. Except as otherwise provided in IC 22-3-2 through IC 22-3-6, the term includes a medical service facility. **The term does not include a medical case manager or another person who assists in the planning, coordination, monitoring, or evaluation of medical services provided to an employee.**

(j) "Medical service facility" means any of the following that provides a service or product under IC 22-3-2 through IC 22-3-6 **and uses the CMS 1450 (UB-04) form for Medicare reimbursement:**

(1) A hospital (as defined in IC 16-18-2-179).

(2) A hospital based health facility (as defined in IC 16-18-2-180).

(3) A medical center (as defined in IC 16-18-2-223.4).

The term does not include a professional corporation (as defined in IC 23-1.5-1-10) comprised of health care professionals (as defined in IC 23-1.5-1-8) formed to render professional services as set forth in IC 23-1.5-2-3(a)(4) or a health care professional (as defined in IC 23-1.5-1-8) who bills for a service or product provided under IC 22-3-2 through IC 22-3-6 as an individual or a member of a group practice **or another medical service provider that uses the CMS 1500 form for Medicare reimbursement.**

(k) "Pecuniary liability" means the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under IC 22-3-2 through IC 22-3-6, as follows:

(1) This subdivision applies before July 1, 2014, to all medical service providers, and after June 30, 2014, to a medical service provider that is not a medical service facility. Payment of the charges in a defined community, equal to or less than the charges

made by medical service providers at the eightieth percentile in the same community for like services or products.

(2) This subdivision applies after June 30, 2014, to a medical service facility. Payment of the charges in a reasonable amount, which is established by payment of one (1) of the following:

(A) The amount negotiated at any time between the medical service facility and any of the following, if an amount has been negotiated:

(i) The employer.

(ii) The employer's insurance carrier.

(iii) A billing review service on behalf of a person described in item (i) or (ii).

(iv) A direct provider network that has contracted with a person described in item (i) or (ii).

(B) **An amount not to exceed** ~~Two~~ **one** hundred **fifty** percent ~~(200%)~~ **(150%)** of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in clause (A).

(C) An amount not less than one hundred twenty-five percent (125%) of the cost to the medical service facility of the specific service or product provided, if an amount has not been negotiated as described in clause (A). For purposes of this clause, "cost" means the expenses incurred by the medical service facility in rendering the patient care, but does not include operating expenses not related to patient care. If the medical service facility disputes a payment made under this clause, neither the amount described in clause (B) nor the amount billed under this clause is presumed to be correct. The worker's compensation board shall accept any evidence that rationally establishes the basis for calculating the medical service facility's cost in determining the amount paid under this clause.

(l) "Service or product" or "services and products" refers to medical, hospital, surgical, or nursing service, treatment, and supplies provided under IC 22-3-2 through IC 22-3-6.

SECTION 4. IC 22-3-7-9, AS AMENDED BY P.L.275-2013, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 9. (a) As used in this chapter, "employer" includes the state and any political subdivision, any municipal corporation

within the state, any individual or the legal representative of a deceased individual, firm, association, limited liability company, or corporation or the receiver or trustee of the same, using the services of another for pay. A parent corporation and its subsidiaries shall each be considered joint employers of the corporation's, the parent's, or the subsidiaries' employees for purposes of sections 6 and 33 of this chapter. Both a lessor and a lessee of employees shall each be considered joint employers of the employees provided by the lessor to the lessee for purposes of sections 6 and 33 of this chapter. The term also includes an employer that provides on-the-job training under the federal School to Work Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth under section 2.5 of this chapter. If the employer is insured, the term includes the employer's insurer so far as applicable. However, the inclusion of an employer's insurer within this definition does not allow an employer's insurer to avoid payment for services rendered to an employee with the approval of the employer. The term does not include a nonprofit corporation that is recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to the extent the corporation enters into an independent contractor agreement with a person for the performance of youth coaching services on a part-time basis.

(b) As used in this chapter, "employee" means every person, including a minor, in the service of another, under any contract of hire or apprenticeship written or implied, except one whose employment is both casual and not in the usual course of the trade, business, occupation, or profession of the employer. For purposes of this chapter the following apply:

(1) Any reference to an employee who has suffered disablement, when the employee is dead, also includes the employee's legal representative, dependents, and other persons to whom compensation may be payable.

(2) An owner of a sole proprietorship may elect to include the owner as an employee under this chapter if the owner is actually engaged in the proprietorship business. If the owner makes this election, the owner must serve upon the owner's insurance carrier and upon the board written notice of the election. No owner of a sole proprietorship may be considered an employee under this chapter unless the notice has been received. If the owner of a sole proprietorship:

(A) is an independent contractor in the construction trades and does not make the election provided under this subdivision, the owner must obtain a certificate of exemption under section

34.5 of this chapter; or

(B) is an independent contractor and does not make the election provided under this subdivision, the owner may obtain a certificate of exemption under section 34.5 of this chapter.

(3) A partner in a partnership may elect to include the partner as an employee under this chapter if the partner is actually engaged in the partnership business. If a partner makes this election, the partner must serve upon the partner's insurance carrier and upon the board written notice of the election. No partner may be considered an employee under this chapter until the notice has been received. If a partner in a partnership:

(A) is an independent contractor in the construction trades and does not make the election provided under this subdivision, the partner must obtain a certificate of exemption under section 34.5 of this chapter; or

(B) is an independent contractor and does not make the election provided under this subdivision, the partner may obtain a certificate of exemption under section 34.5 of this chapter.

(4) Real estate professionals are not employees under this chapter if:

(A) they are licensed real estate agents;

(B) substantially all their remuneration is directly related to sales volume and not the number of hours worked; and

(C) they have written agreements with real estate brokers stating that they are not to be treated as employees for tax purposes.

(5) A person is an independent contractor in the construction trades and not an employee under this chapter if the person is an independent contractor under the guidelines of the United States Internal Revenue Service.

(6) An owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376, to a motor carrier is not an employee of the motor carrier for purposes of this chapter. The owner-operator may elect to be covered and have the owner-operator's drivers covered under a worker's compensation insurance policy or authorized self-insurance that insures the motor carrier if the owner-operator pays the premiums as requested by the motor carrier. An election by an owner-operator under this subdivision does not terminate the independent contractor status of the owner-operator for any purpose other than

the purpose of this subdivision.

(7) An unpaid participant under the federal School to Work Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the extent set forth under section 2.5 of this chapter.

(8) A person who enters into an independent contractor agreement with a nonprofit corporation that is recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to perform youth coaching services on a part-time basis is not an employee for purposes of this chapter.

(9) An officer of a corporation who is the sole officer of the corporation is an employee of the corporation under this chapter. An officer of a corporation who is the sole officer of the corporation may elect not to be an employee of the corporation under this chapter. If an officer makes this election, the officer must serve written notice of the election on the corporation's insurance carrier and the board. An officer of a corporation who is the sole officer of the corporation may not be considered to be excluded as an employee under this chapter until the notice is received by the insurance carrier and the board.

(10) An individual who is not an employee of the state or a political subdivision is considered to be a temporary employee of the state for purposes of this chapter while serving as a member of a mobile support unit on duty for training, an exercise, or a response, as set forth in IC 10-14-3-19(c)(2)(B).

(c) As used in this chapter, "minor" means an individual who has not reached seventeen (17) years of age. A minor employee shall be considered as being of full age for all purposes of this chapter. However, if the employee is a minor who, at the time of the last exposure, is employed, required, suffered, or permitted to work in violation of the child labor laws of this state, the amount of compensation and death benefits, as provided in this chapter, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of the compensation or benefits that may be payable on account of the disability or death of the minor, and the employer shall be wholly liable for the other one-half (1/2) of the compensation or benefits. If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age, and who at the time of the last exposure is employed, suffered, or permitted to work at any occupation which is not prohibited by law, the provisions of this subsection prescribing double the amount otherwise recoverable do not apply. The rights and remedies granted to a minor under this chapter on

account of disease shall exclude all rights and remedies of the minor, the minor's parents, the minor's personal representatives, dependents, or next of kin at common law, statutory or otherwise, on account of any disease.

(d) This chapter does not apply to casual laborers as defined in subsection (b), nor to farm or agricultural employees, nor to household employees, nor to railroad employees engaged in train service as engineers, firemen, conductors, brakemen, flagmen, baggagemen, or foremen in charge of yard engines and helpers assigned thereto, nor to their employers with respect to these employees. Also, this chapter does not apply to employees or their employers with respect to employments in which the laws of the United States provide for compensation or liability for injury to the health, disability, or death by reason of diseases suffered by these employees.

(e) As used in this chapter, "disablement" means the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom the employee claims compensation or equal wages in other suitable employment, and "disability" means the state of being so incapacitated.

(f) For the purposes of this chapter, no compensation shall be payable for or on account of any occupational diseases unless disablement, as defined in subsection (e), occurs within two (2) years after the last day of the last exposure to the hazards of the disease except for the following:

(1) In all cases of occupational diseases caused by the inhalation of silica dust or coal dust, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within three (3) years after the last day of the last exposure to the hazards of the disease.

(2) In all cases of occupational disease caused by the exposure to radiation, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within two (2) years from the date on which the employee had knowledge of the nature of the employee's occupational disease or, by exercise of reasonable diligence, should have known of the existence of such disease and its causal relationship to the employee's employment.

(3) In all cases of occupational diseases caused by the inhalation of asbestos dust, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within three (3) years after the last day of the last exposure to the hazards of the disease if the last day of the last exposure was before July 1, 1985.

(4) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1985, and before July 1, 1988, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within twenty (20) years after the last day of the last exposure.

(5) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1988, no compensation shall be payable unless disablement (as defined in subsection (e)) occurs within thirty-five (35) years after the last day of the last exposure.

(g) For the purposes of this chapter, no compensation shall be payable for or on account of death resulting from any occupational disease unless death occurs within two (2) years after the date of disablement. However, this subsection does not bar compensation for death:

(1) where death occurs during the pendency of a claim filed by an employee within two (2) years after the date of disablement and which claim has not resulted in a decision or has resulted in a decision which is in process of review or appeal; or

(2) where, by agreement filed or decision rendered, a compensable period of disability has been fixed and death occurs within two (2) years after the end of such fixed period, but in no event later than three hundred (300) weeks after the date of disablement.

(h) As used in this chapter, "billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(i) As used in this chapter, "billing review standard" means the data used by a billing review service to determine pecuniary liability.

(j) As used in this chapter, "community" means a geographic service area based on ZIP code districts defined by the United States Postal Service according to the following groupings:

(1) The geographic service area served by ZIP codes with the first three (3) digits 463 and 464.

(2) The geographic service area served by ZIP codes with the first three (3) digits 465 and 466.

(3) The geographic service area served by ZIP codes with the first three (3) digits 467 and 468.

(4) The geographic service area served by ZIP codes with the first

three (3) digits 469 and 479.

(5) The geographic service area served by ZIP codes with the first three (3) digits 460, 461 (except 46107), and 473.

(6) The geographic service area served by the 46107 ZIP code and ZIP codes with the first three (3) digits 462.

(7) The geographic service area served by ZIP codes with the first three (3) digits 470, 471, 472, 474, and 478.

(8) The geographic service area served by ZIP codes with the first three (3) digits 475, 476, and 477.

(k) As used in this chapter, "medical service provider" refers to a person or an entity that provides services or products to an employee under this chapter. Except as otherwise provided in this chapter, the term includes a medical service facility. **The term does not include a medical case manager or another person who assists in the planning, coordination, monitoring, or evaluation of medical services provided to an employee.**

(l) As used in this chapter, "medical service facility" means any of the following that provides a service or product under this chapter **and uses the CMS 1450 (UB-04) form for Medicare reimbursement:**

(1) A hospital (as defined in IC 16-18-2-179).

(2) A hospital based health facility (as defined in IC 16-18-2-180).

(3) A medical center (as defined in IC 16-18-2-223.4).

The term does not include a professional corporation (as defined in IC 23-1.5-1-10) comprised of health care professionals (as defined in IC 23-1.5-1-8) formed to render professional services as set forth in IC 23-1.5-2-3(a)(4) or a health care professional (as defined in IC 23-1.5-1-8) who bills for a service or product provided under this chapter as an individual or a member of a group practice **or another medical service provider that uses the CMS 1500 form for Medicare reimbursement.**

(m) As used in this chapter, "pecuniary liability" means the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under this chapter as follows:

(1) This subdivision applies before July 1, 2014, to all medical service providers, and after June 30, 2014, to a medical service provider that is not a medical service facility. Payment of the charges in a defined community, equal to or less than the charges made by medical service providers at the eightieth percentile in the same community for like services or products.

(2) This subdivision applies after June 30, 2014, to a medical

service facility. Payment of the charges in a reasonable amount, which is established by payment of one (1) of the following:

(A) The amount negotiated at any time between the medical service facility and any of the following, if an amount has been negotiated:

(i) The employer.

(ii) The employer's insurance carrier.

(iii) A billing review service on behalf of a person described in item (i) or (ii).

(iv) A direct provider network that has contracted with a person described in item (i) or (ii).

(B) **An amount not to exceed** ~~Two~~ **one** hundred **fifty** percent ~~(200%)~~ **(150%)** of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in clause (A).

(C) An amount not less than one hundred twenty-five percent (125%) of the cost to the medical service facility of the specific service or product provided, if an amount has not been negotiated as described in clause (A). For purposes of this clause, "cost" means the expenses incurred by the medical service facility in rendering the patient care, but does not include operating expenses not related to patient care. If the medical service facility disputes a payment made under this clause, neither the amount described in clause (B) nor the amount billed under this clause is presumed to be correct. The worker's compensation board shall accept any evidence that rationally establishes the basis for calculating the medical service facility's cost in determining the amount paid under this clause.

(n) "Service or product" or "services and products" refers to medical, hospital, surgical, or nursing service, treatment, and supplies provided under this chapter.

SECTION 5. IC 22-3-7-17.2, AS AMENDED BY P.L.275-2013, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 17.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter provided before July 1, 2014, by all medical service providers, and after June 30, 2014, by a medical

service provider that is not a medical service facility:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(b) This subsection applies after June 30, 2014, to a medical service facility. The pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under ~~worker's compensation~~ **this chapter** and provided by a medical service facility is equal to a reasonable amount, which is established by payment of one (1) of the following:

(1) The amount negotiated at any time between the medical service facility and any of the following:

(A) The employer.

(B) The employer's insurance carrier.

(C) A billing review service on behalf of a person described in clause (A) or (B).

(D) A direct provider network that has contracted with a person described in clause (A) or (B).

(2) **An amount not to exceed** ~~Two~~ **one** hundred **fifty** percent ~~(200%)~~ **(150%)** of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1).

(3) An amount not less than one hundred twenty-five percent

(125%) of the cost to the medical service facility of the specific service or product provided, if an amount has not been negotiated as described in subdivision (1). For purposes of this subdivision, "cost" means the expenses incurred by the medical service facility in rendering the patient care, but does not include operating expenses not related to patient care. If the medical service facility disputes a payment made under this subdivision, neither the amount described in subdivision (2) nor the amount billed under this subdivision is presumed to be correct. The worker's compensation board shall accept any evidence that rationally establishes the basis for calculating the medical service facility's cost in determining the amount paid under this subdivision.

(c) The payment to a medical service provider for an implant furnished to an employee under this chapter may not exceed the **amount of the medical service facility's actual acquisition cost as evidenced by an** invoice ~~amount~~ **from the implant manufacturer to the medical service facility** plus twenty-five percent (25%). **The actual acquisition cost must be reduced by the amount of any financial incentive that the medical service facility receives or benefits from in connection with the implant, including a rebate, discount, recall, or reduction. A medical service provider may not receive more than one (1) reimbursement for an implant furnished to an employee under this chapter.**

(d) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) or Medicare coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; and

(4) in the case of a CPT or Medicare coding change, the basis upon which the change was made;

not later than thirty (30) days after the date of the request.

(e) If, after a hearing, the worker's compensation board finds that a billing review service used a billing review standard that did not comply with subsection (a)(1) through (a)(3), as applicable, in

determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under occupational disease compensation, the worker's compensation board may assess a civil penalty against the billing review service in an amount not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000).

SECTION 6. IC 22-3-7-17.4, AS ADDED BY P.L.275-2013, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 17.4. (a) As used in this section, "legend drug" has the meaning set forth in IC 25-26-14-7.

(b) As used in this section, "repackage" has the meaning set forth in IC 25-26-14-9.3.

(c) This subsection does not apply to a retail or mail order pharmacy. Except as provided in subsection (d), whenever a prescription covered by this chapter is filled using a repackaged legend drug:

(1) the maximum reimbursement amount for the repackaged legend drug must be computed using the average wholesale price set by the original manufacturer for the legend drug;

(2) the medical service provider may not be reimbursed for more than one (1) office visit for each repackaged legend drug prescribed; and

(3) the maximum period during which a medical service provider may receive reimbursement for a repackaged legend drug begins on the date of the disablement and ends at the beginning of the eighth day after the date of the disablement.

(d) If the National Drug Code (established under Section 510 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 360) for a legend drug cannot be determined from the medical service provider's billing or statement, the maximum reimbursement amount for the repackaged legend drug under subsection (c) is the lowest cost generic for that legend drug.